FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

MPA/156800

PRELIMINARY RECITALS

Pursuant to a petition filed April 09, 2014, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on May 20, 2014, at Milwaukee, Wisconsin.

The issue for determination is whether Petitioner has submitted evidence sufficient to demonstrate that additional personal care worker (PCW) hours may be paid for by the Medicaid program.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Robert Derendinger, RN
Division of Health Care Access and Accountability
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

ADMINISTRATIVE LAW JUDGE:
David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Milwaukee County.
2. A prior authorization (PA) request seeking Medicaid payment for 35.25 hours (or 141 units with each unit = 15 minutes) per week of personal care services and 96 units or 24 hours for as needed (PRN) PCW care was filed on behalf of Petitioner on or about February 21, 2014. The total cost was noted to be $37,845.00. The requesting provider is [redacted] HealthCare, LLC. The request was for 53 weeks. A Personal Care Screening Tool assessment was completed on February 19, 2014 and was the basis for the request.

3. Petitioner is 56 years of age (DOB 10/28/1957). He lives alone in the community though his relative caregiver(s) (a daughter-in-law and/or daughter) lives in the same apartment building albeit in different units. Petitioner suffered a head trauma in a 1998 mugging that left him impaired. Prior to that he had been a US Navy radio operator. The diagnoses noted on the first page of the PA request are 'uns pers ment dis in ot cond' [sic] and 'HIV disease'. Other documentation in the record indicates that Petitioner also has the following diagnosis – umbilical hernias, kidney disease, hypertension, depression and sickle cell disease. His functional limitations are noted to be endurance, ambulation and problems with speech. Documentation indicates use of a cane and a walker. Though he is described as being oriented he has memory difficulties. He takes a number of medications.

4. Petitioner is married but his wife lives in her own subsidized apartment. She receives PCW services form the same provider but comes to Petitioner's home to provide some help and/or supervision.

5. The PRN time was approved. The Department also approved a modified amount of personal care hours for Petitioner; rather than the requested 35.25 hours per week, the Department approved 17.5 hours per week with the approved tasks and times as follows (per Ex # 3 at page 8):

• Bathing	210 min/wk
• Grooming	105 min/wk
• Mobility	140 min/wk
• Toileting	210 min/wk
• -Services incidental to these tasks (1/3 of above total)	222 min/wk
• Medical condition (.25 of total)	166 min/wk

Total: 1053 min or 17.5 hrs. or 70 units (rounded).

No time was allocated for dressing, eating, transfers, or medication administration.

6. The Department also approved 96 units of PCW services to be used as needed during the course of the 53 weeks.

7. Petitioner also receives self-directed services through the Include, Respect, I Self Direct (IRIS) program. It is not clear as to how the fee for service Medicaid program and the IRIS program coordinate services for Petitioner. A Long Term Care – Functional Screen was completed on April 22, 2014.

8. Petitioner also receives some medical care through the Veteran's Administration.

DISCUSSION

When determining whether to approve any medical service, the OIG must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, §* DHS *107.02(3) (e)*:

> (e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:
> 1. The medical necessity of the service;
> 2. The appropriateness of the service;
> 3. The cost of the service;
> 4. The frequency of furnishing the service;
> 5. The quality and timeliness of the service;
> 6. The extent to which less expensive alternative services are available;
> 7. The effective and appropriate use of available services;

8. The misutilization practices of providers and recipients;
9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

"Medically necessary" means a medical assistance service under ch. DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.
Wis. Admin. Code, §DHS 101.03(96m).

Also, the following Administrative Code provision is relevant here:

DHS 107.112 Personal care services. (1) COVERED SERVICES. (a) Personal care services are medically oriented activities related to assisting a recipient with activities of daily living necessary to maintain the recipient in his or her place of residence in the community. These services shall be provided upon written orders of a physician by a provider certified under s. DHS 105.17 and by a personal care worker employed by the provider or under contract to the provider who is supervised by a registered nurse according to a written plan of care. The personal care worker shall be assigned by the supervising registered nurse to specific recipients to do specific tasks for those recipients for which the personal care worker has been trained. The personal care worker's training for these specific tasks shall be assured by the supervising registered nurse. The personal care worker is limited to performing only those tasks and services as assigned for each recipient and for which he or she has been specifically trained.

(b) Covered personal care services are:
1. Assistance with bathing;
2. Assistance with getting in and out of bed;
3. Teeth, mouth, denture and hair care;
4. Assistance with mobility and ambulation including use of walker, cane or crutches;
5. Changing the recipient's bed and laundering the bed linens and the recipient's personal clothing;
6. Skin care excluding wound care;
7. Care of eyeglasses and hearing aids;
8. Assistance with dressing and undressing;
9. Toileting, including use and care of bedpan, urinal, commode or toilet;

10. Light cleaning in essential areas of the home used during personal care service activities;
11. Meal preparation, food purchasing and meal serving;
12. Simple transfers including bed to chair or wheelchair and reverse; and
13. Accompanying the recipient to obtain medical diagnosis and treatment.
Wis. Admin. Code, §DHS 107.112(1)(a) and (b).

I note at this point that the Petitioner has the burden of proving that the requested therapy meets the approval criteria and that the standard level of proof applicable is a "preponderance of the evidence". This legal standard of review means, simply, that "it is more likely than not" that Petitioner and/or his/her representatives have demonstrated that the requested services meet the criteria necessary for payment by the Wisconsin Medicaid program. It is the lowest legal standard in use in courts or tribunals.

The Department provided a 9 page letter (Ex # 3) that detailed its rationale for modifying this request for personal care services. It need not be reproduced here in its entirety as it is in the record as Exhibit # 3. Essentially, it indicates that the Department found a conflict between the PCST and the LTFS with the LTFS suggesting more capability than the PCST. It also found the medical documentation did not support the request.

Petitioner was represented at the hearing by his wife with Petitioner listening in as the phone was in speaker mode. Petitioner's wife testified that his condition has changed since the filing of this PA. She testified that Petitioner needs complete assistance with toileting, assistance with dressing, assistance with transfers and medication assistance. She testified that petitioner must now use a pull-up diaper and is easier to change that several times a day than to get him to the bathroom but that this necessitates additional time with bathing as he must be bathed after each change. She testified that he has been recently diagnosed with having had a stroke. She believes that the stroke occurred in November of 2013 but that was not diagnosed until April 2014. She does allow that Petitioner has good days where he is more capable and bad days where he has reduced ability to take care of his activities of daily living. Petitioner was offered a chance to add to his wife's testimony but he indicated that she had made the major points.

There is a conflict between the provider submission, a long-term care functional screen completed for the IRIS program and the testimony of Petitioner's wife. The IRIS program screening was completed in April 2014. It indicates that Petitioner needs help with bathing and dressing but that he only needed some supervision with mobility and toileting and that the caregiver need not be present. It indicates that while Petitioner is independent as to toileting but he has an incontinence episode approximately once per week. It found Petitioner to be independent as to transfers and eating.

I am sustaining the Department denial. The evidence is just not sufficient at this time to add PCW hours. There are significant questions about the coordination of benefits with the IRIS program. There are dichotomies between the testimony of Petitioner's spouse, the PCST completed in February 2014 and the LTFS completed in April 2014. Petitioner's spouse indicated that the provider that submitted this PA might have been able to better document the changes but that the personnel that Petitioner deals with have been on maternity leave. It is not clear from the medical documentation how Petitioner went from being independent as to toileting in April 2014 per the LTFS to being completely diaper dependent by the time of the hearing. The medical documentation of April 2014 does not show that degree of physical decline. I also note that the stroke diagnosis from April 2014 is not particularly strong or even a definitive diagnosis. Finally, while testimony for Petitioner was that help is required for medication administration, medication management is not a service that this provider including in its services so cannot be added to this PA.

Petitioner may note that a new prior authorization request can be filed, especially if circumstances change and/or better documentation is available.

NOTE: The provider will not receive a copy of this Decision. It is suggested that Petitioner share it with the provider.

CONCLUSIONS OF LAW

That the evidence offered on behalf of Petitioner is not sufficient to demonstrate that additional hours of personal care services meet the standards necessary for payment by Medicaid at this time.

THEREFORE, it is ORDERED

That this appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 8th day of July, 2014

\sDavid D. Fleming
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on July 8, 2014.

Division of Health Care Access and Accountability